



APPLICATION FORM

DATE _____ WHERE DID YOU HEAR ABOUT AFH-KANB? _____

POST APPLIED FOR _____ SPECIALTY _____

NAME _____ FATHER'S NAME _____

CP. NO. _____ E-MAIL ADD. _____

CITY ADDRESS _____

PROVINCIAL ADDRESS _____

GENDER _____ DATE OF BIRTH _____ PLACE OF BIRTH _____

CIVIL STATUS _____ CITIZENSHIP _____ WEIGHT _____ HEIGHT _____

LANGUAGE OR DIALECT YOU CAN SPEAK OR WRITE _____

PHOTO

EDUCATIONAL BACKGROUND:

HIGH SCHOOL _____ DATE GRADUATED _____

UNIVERSITY _____ DATE GRADUATED _____

POST GRADUATE _____ DATE GRADUATED _____

COURSES _____

SPECIAL SKILLS _____

SAUDI HEALTH COUNCIL NO. _____ DATE OF ISSUE _____ VALIDITY _____

EMPLOYMENT RECORD: (From Present to Previous)

| POSITION | COMPANY | FROM | TO |
|----------------------|---------|------|----|
| | | | |
| | | | |
| | | | |
| TRAININGS (If Any) : | | | |

REFERENCES:

| NAME | OCCUPATION | CONTACT NO. |
|--|------------|-------------|
| | | |
| | | |
| Name of relative working in AFH-KANB (if any): | | |

The information given in this application are true and correct, any false statement made herein will be sufficient cause for immediate separation from the service to hospital upon discovery thereof regardless of when such fact be discovered.

HRD-REC-0001

SIGNATURE: